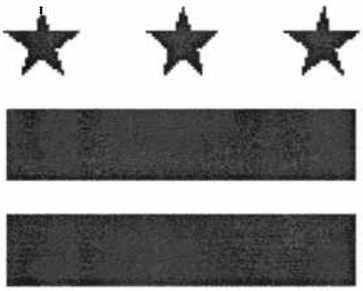
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES



Department on Disability Services	Policy Number: 4.6
Responsible Program or Office: The Developmental Disabilities Administration (DDA)	Number of Pages: 14
Date of Approval by the Director: December 31, 2007	Number of Attachments: One.
Effective Date: Immediately. See Section 9 -- Timeline for Implementation	Expiration Date, if Any: None.
Supercedes Policy Dated: None.	
Cross References and Related Policies: **Policies and Procedures on Intensive Case Management, Case Management; Individual Support Plan; Nurse Monitoring; and Substitute Decision-making for Emergency Care and Urgent Care Medical Needs**	
Subject: **DDS Policy on Identifying, Diagnosing and Treating Ongoing Health and Functional Decline Presented in Individuals Receiving DDA Services.**	

1. PURPOSE

This policy establishes standards and procedures to ensure that the Developmental Disabilities Administration (DDA) and its providers have protocols in place to

guarantee that individuals presented with ongoing functional and health decline, receive adequate medical evaluation and appropriate treatment in a timely manner in an effort to identify the etiology of the problem(s). This policy shall also ensure that the interdisciplinary team (IDT) closely monitors these individuals, develops and implements appropriate action plans/interventions, and revises the individual Service Plan (ISP) as necessary.

2. APPLICABILITY

This policy applies to all DDS employees, subcontractors, providers, vendors, consultants, health care professionals, volunteers, and governmental agencies that provide services and supports to individuals with developmental disabilities.

3. AUTHORITY

The authority and functions of the Department on Disability Services as set forth in Act 16-672, effective December 29, 2006.

4. POLICY

It is the policy of DDS that individuals receiving assistance from DDA should receive high quality health care services in a timely and appropriate manner. In general, having developmental disabilities does not preclude someone from leading a healthy life and in fact, many individuals are currently leading such lives. Many individuals enjoy stable health and require only routine and episodic health care interventions, but others have complex health care needs or newly diagnosed conditions that require a more sophisticated clinical review and an in depth health care management plan. Furthermore, research indicates that many people with developmental disabilities have historically faced and continue to experience significant health disparities and other barriers that prevent them from obtaining the best possible care.[1] Issues that may compromise or completely undermine the quality of health care services that such persons may receive include:

- Difficulty of the individual to communicate symptoms to both direct support professionals and health care providers,
- Limited experience of direct support professionals to communicate necessary and pertinent information to the health care provider during routine, urgent or episodic visits.
- Incomplete or poorly communicated information from the health care provider that impacts follow-up and ongoing health care management.
- Lack of complete and thorough medical histories needed to enable a health care provider to make appropriate assessments, diagnoses and treatment recommendations.
- Limited awareness and understanding that people with developmental disabilities are often at risk for health and disabling conditions that, while

secondary to their primary conditions, may potentially undermine their health if not effectively managed.

- Lack of consistent routine/preventive health care screening standards adjusted for age and specific syndromes or secondary disabilities associated with certain developmental disabilities.
- Lack of systems to observe and report changes in health and mental health status.
- Lack of systems to trigger a clinical consultation when certain health care issues emerge.

At a minimum, if these problems are not effectively identified and addressed, they may invariably lead to less than optimal and appropriate care. In extreme cases, the impact may be irreversible or fatal.

Individuals experiencing ongoing functional and health decline(s) are particularly at risk for suffering the most severe consequences of a lack of a proactive, comprehensive approach to appropriate care and treatment. For the purpose of this policy, on-going functional and/or health decline is defined broadly as:

> Any continuing change(s) in the physical or mental health and/or functional abilities of an individual that could cause, exacerbate or increase the risk of an illness, injury, chronic pain, Emergency Room visits/hospitalization, institutionalization, on-going intrusive medical care or result in death.

The purpose of this policy, therefore, is to set forth clear and consistent standards, protocols and procedures that all DDA employees, providers, and health professionals responsible for providing, contracting for and/or overseeing services and supports to individuals receiving DDA services and supports must follow when an individual presents signs and symptoms that he or she is experiencing ongoing health and/or functional decline(s).

For the definitions of other **key terms** used in this policy, please refer to Section 10 -- Glossary of Key Terms.

5. RESPONSIBILITY

The responsibility for implementation of this policy is vested with the Deputy Director of the Department on Disability Services for the Developmental Disabilities Administration.

6. STANDARDS

In order to ensure compliance with this policy, all DDS service providers shall adhere to the following standards in several critical areas:

Medical Records:

- The records of individuals receiving DDA services are the property of DDS and complete records must be turned over to DDS in the event a provider ceases to provide services.
- An accurate, complete, and up to date set of medical records shall be maintained by the residential support provider for each individual it provides services and supports.
- The residential support provider shall also be responsible for identifying any gaps or inconsistencies that exist in the medical records and shall also work with DDS, the individual's team, and the PCP to resolve them in a timely manner.
- An individual's medical records shall be maintained in this manner to ensure that they can provide a critical baseline and ongoing information that is essential to diagnosing and caring for the individual, especially during a period of crisis or decline.

Medical Documentation:

- An individual's medical records must at a minimum include:
  - A detailed and thorough medical history needed to enable a health care provider to make appropriate assessments, diagnoses and treatment recommendations.
  - Clear and consistent documentation as to the person's current health status, including information on all active health problems and detailed actions being taken to diagnose, treat and/or remediate each problem.
  - Documentation that a comprehensive and individualized Health Care Management Plan (HCMP) is developed and implemented for all active and potential problems in a timely and appropriate manner.
  - Nursing documentation that includes the date and time of entry, documents the assessed problem, the intervention taken and evaluation as to the effectiveness of the intervention. Any instruction given to direct support staff should also be included along with documentation of any discussion(s) with the physician and/or other relevant team members specific to an identified problem.
  - Clear evidence of the HCMP's implementation, including observations, objective progress toward goals, review of data, and recommendations for improvement, plan revisions as indicated, staff training, etc.
  - Clear evidence that acute illnesses/injuries (e.g.,flu/colds, head injuries, elevated temperature, fractures etc.) are monitored and addressed at a frequency consistent with handling the problem through to its ultimate resolution.
  - Completed DDA Health Care Forms 1,2, and 3.
  - Annual nursing assessment that shows evidence of quarterly updates.
  - Completed and current DDA Health Passport that also demonstrates that it is reflective of the information contained in the HCMP.

- All information included in an individual's medical records must be entered in a highly legible and easy to understand manner. At minimum, all documentation will reflect:
    - Presenting issue(s)/observation(s)
    - Assessment and/or findings
    - Intervention in clear steps, or the justification for no action taken
    - Follow-up recommendations (i.e., what steps are recommended, when it should be done by and by whom)
    - If appropriate: Who is to be notified/copied

- Each individual's medical records must be organized in an integrated manner that promotes a clear and coherent understanding of the person's health status and how it is changing or remaining stable over time.

Ready Access to Medical Information:

- The residential support provider shall maintain a current, up to date "Health Passport" for each individual it supports.
- The Health Passport shall serve as the portable health document for each person that accurately captures their medical and health status/history, known risks, active problems and current medications for other health care professionals. But, it shall not be seen as a substitute for providing health care professionals complete access to the complete or relevant portions of an individual's medical records when necessary to diagnose and/or treat him or her.
- The residential support provider shall make the medical records of an individual available to any health professional that is treating or conducting diagnostic tests on the person in a timely manner consistent with their health needs.
- All medical consultants and health care providers shall receive current and relevant information when evaluating an individual, including but not limited to:
    - A clear statement as to why the consultation has been requested/scheduled, including the type of information that it is expected that the consultation will help to produce,
    - Current medications including the purpose each is prescribed, the dosages, possible side effects and contra-indications,
    - Current lab reports and relevant diagnostic test reports, and
    - A current, up-to-date Health Passport for the individual.
- An accurate and current active problem list shall be maintained and regularly updated as a separate and distinct document that is easily accessible to all health care providers.

Results from each medical visit:

- The provider will assure that all related health care professionals delivering services to individuals will provide the following documentation for each contact with the person, and will, at minimum, include:
    - Reason for the contact/visit
    - Findings of the visit
    - Recommendations/interventions

- Follow-up actions to be taken (when and what)

Monitoring for, Identifying and Responding to Signs of Decline:

- Each residential support provider, PCP and other providers that offer services and supports to individuals shall develop and implement practices and protocols that are consistent with this policy for recognizing and responding to possible signs of ongoing health and/or functional decline in the individuals they provide services to and support.
- Providers, PCPs and others covered by this policy shall participate in required competency based training that will be provided on a regular basis by DDS on the best methods/practices to recognize and respond to signs and known evidence of ongoing health and/or functional decline in the individuals with developmental disabilities.

Differential Diagnosis:

- When attempting to diagnose the cause(s) of a health and/or functional decline of an unknown etiology in an individual, the PCP and other health professionals involved in his or her care shall adhere to the principles of differential diagnosis. At a minimum, this shall mean that the diagnosis must be approached as a systematic, rigorous process for:
    - Weighing the probability of one possible cause against one or more others;
    - Carefully monitoring and assessing whether a particular working diagnosis proves accurate; and,
    - Reassessing diagnoses when an individual's condition does not improve.
- The PCP and other health professionals involved in his or her care shall adhere to the principles of differential diagnosis in order to:
    - More clearly understand the individual's declining health and/or functional status;
    - Ameliorate such declines to the maximum extent possible;
    - Assess what a reasonable prognosis for the individual may be;
    - Plan treatment or intervention for the condition or circumstance; and,
    - Better enable the individual to adjust to such decline in his or her life.

Diagnosing the Etiology of Ongoing Health and/or Functional Decline:

- When an individual is either suspected or known to be experiencing ongoing health and/or functional decline, the residential support provider shall assure:
    - The individual's PCP conducts a timely and adequate medical evaluation in an effort to identify the etiology of the problem(s);
    - The PCP makes timely referrals to medical consultants and specialists to diagnose and treat the condition(s); and,

- Any recommendations resulting from such visits are acted upon in a timely manner consistent with the interests and health care needs of the individual;
- Medication side effects/adverse effects and drug-to-drug interactions shall be consistently monitored, documented and considered in relation to an individual's presenting health issues.
- Similarly, side effects/adverse effects and drug-to-drug interactions also must always be considered in the presence of behavioral episodes and somatic complaints.
- The residential support provider also shall inform and regularly update the individual's DDS service coordinator and team of the person's status and condition.

Documenting Follow Up to Consultants Recommendations:

- Whenever a medical consultant or specialist makes a recommendation for a specific action to the PCP regarding the diagnosis, care and/or treatment of such an individual, the following must be documented in the medical records:
  - The exact recommendation that was made by the medical consultant or specialist (including the recommended timeframe for implementing it);
  - Whether or not the PCP decided to implement the recommendation as stated and specify the timeframe that the implementation occurred within;
  - Whether or not the PCP decided to take alternative actions, the stated rationale for doing so and the timeframe this action(s) occurred within;
  - Whether or not the PCP decided to take alternative actions and their rationale for making this decision; and
  - A description of any other barriers or delays experienced in implementing such recommendations and specify the actions being taken to address such problems.

The Role and Responsibility of the Interdisciplinary Team (IDT):

- When an individual is either suspected or known to be experiencing ongoing health and/or functional decline, the IDT shall meet and communicate as frequently as possible to:
  - Closely monitor the individual's changing needs and abilities;
  - Develop and implement appropriate action plans/interventions, and
  - Revise the individual's services plan (ISP) as indicated.
- The IDT shall also determine and make a recommendation to the service coordinator as to whether or not the individual:
  - Currently has the capacity to make his or her own health care decisions, or

- Currently has a family member who provides substitute consent for health care decisions for them and who is willing and able to continue to perform this function, or
- Requires in the IDT's view, a legal guardian to be appointed for the individual to perform this limited function.

- As the individual's diagnosis, prognosis, and changing condition warrants, the IDT shall assess whether and when end of life planning should be appropriately considered, discussed, and initiated with the individual (when possible), family members, and guardians.

Health Care Substitute Decision Making:

- If in the IDT or provider's view, a legal guardian needs to be appointed for the individual for health care decision-making, the provider shall immediately request that the petition process be initiated by the service coordinator as specified by the DDS Policy and Procedures on Substitute Health Care Decision Making (**Policy Number: 4.5**).

Obtaining Emergency Care Without Consent When Necessary:

- In a situation where an individual is in need of emergency health care and needs but lacks a substitute health care decision maker, the individual's residential support provider shall make maximal efforts to ably employ the two-professional rule from D.C. Official Code § 21-2204. In brief, this rule provides for two certifying professionals -- a physician and a qualified psychologist or psychiatrist -- to make a determination of mental incapacity of the individual in such circumstances.
- If the individual is certified to be incapacitated in this manner, the individual's residential support provider shall make maximal efforts to employ D.C. Official Code § 21-2212(c), which states that:

> Emergency health care may be provided without consent to a patient who is certified incapacitated under § 21-2204 if no authorized person is reasonably available or if, in the reasonable medical judgment of the attending physician, attempting to locate an authorized person would cause: (1) A substantial risk of death; (2) The health of the incapacitated individual to be placed in serious jeopardy; (3) Serious impairment to the incapacitated individual's bodily functions; or (4) Serious dysfunction of any bodily organ or part.

- However, these provisions shall not be used on a continuing basis in lieu of obtaining a substitute health care decision maker who is either a family member or a guardian that is appointed by the DC Probate Court for this purpose.

Pain management:

- Whenever an individual has a condition(s) known to cause pain/discomfort, the PCP and residential support provider shall ensure he or she has an adequate and appropriate pain management plan in place and is being assessed for pain at a frequency consistent with the problem.

7. PROCEDURES

While many individuals receiving DDA services and supports enjoy stable health and require only routine and episodic health care interventions, a small percentage of the population have complex health care issues or newly diagnosed conditions that require a more sophisticated clinical review and an in depth health care management plan. The latter is especially true with regard to an individual who is either suspected or known to be experiencing ongoing health and/or functional decline,

The purpose of these policies and procedures is, therefore, to establish clear and consistent standards, protocols and procedures that all DDA employees, providers and health professionals responsible for providing, contracting for and/or overseeing services and supports to individuals receiving DDA services and supports must follow when an individual for whom they are providing services and supports presents signs and symptoms that he or she is experiencing ongoing health and/or functional decline(s). In order to comply with this basic requirement, each residential support provider shall:

- Develop, provide staff training on and implement a written set of policies, procedures and protocols in accordance with this DDS Policy on Identifying, Diagnosing and Treating Health and Functional Decline. At a minimum, such a policy shall incorporate and address each of the specific requirements and elements included in this DDS Policy.
- Implement and comply with the DDS Protocol for Obtaining a DDA Clinical Consultation set forth below.

8. Protocol for Obtaining a DDA Clinical Consultation

The following information is a protocol for a clinical consultation for individuals with physical health care issues that by virtue of their complexity or need for management, require more in depth review than is typical of the standard ISP or other planning processes. Its primary purpose is to provide an opportunity for clinicians to offer valuable guidance to those supporting an individual regarding the specific issues a particular medical condition might present and the programs and supports that will assist the person to manage the condition effectively.

Health Status Indicators that Require DDA Clinical Consultation

The following list represents several conditions or factors which must trigger the need for an in depth clinical consultation. The list is not meant to be all-inclusive. Providers and/or

service coordinators may request a clinical consultation if in their professional judgment, there are issues which require further attention.

1. **Frequent Emergency Room visits or hospitalizations**: This would apply to ER visits and hospitalizations that are not expected as a result of a particular chronic condition or as part of a protocol for management of a chronic condition. For example, visits and hospitalizations for pneumonia or sepsis would be included. In contrast, visits and hospitalizations to manage G/J tube placement or side effects from cancer treatment would not be included.

2. **Newly diagnosed or pre-existing conditions including:** The conditions listed below typically require some major adjustment in the support structure for the individual especially concerning staff training, clinical support and the appropriateness of current placement:

    a. Diabetes
    b. Cancer
    c. Dementia (including Alzheimer's Disease, organic brain syndrome)
    d. Cardiac or Pulmonary condition (For example, angina, congestive heart failure, emphysema, asthma, pulmonary edema, coronary artery disease)
    e. Autoimmune Condition (AIDS, HIV positive, Lupus)
    f. CVA (stroke)
    g. Dysphagia (swallowing difficulties that require specific intervention as ordered by the HMCP or speech or occupational therapist)
    h. Unplanned weight loss or gain
    i. Malnutrition/Obesity
    j. Skin breakdown/pressure ulcers
    k. Contractures/Musculoskeletal concerns
    l. Conditions for which an individual maybe at risk for based on their familial, racial or ethnic background (e.g., diabetes, prostrate or breast cancer)
    m. Any other condition that is secondary to primary diagnosis

3. **Major chronic condition with deteriorating outcome**: (Conditions that would be included here are those that, other than those listed above and below, create major lifestyle adjustments for individuals and their care providers and are likely to change the level of support an individual requires. Some examples are: Traumatic Brain Injury, Multiple Sclerosis, Parkinson's Disease, Huntington's Chorea, Kidney disease requiring dialysis, Cirrhosis, Amyotrophic lateral sclerosis, HIV, Axis I Diagnosis, Hypertension, COPD, and Hypercholesteremia.

4. **Recently placed or malfunctioning G/J tube or other implantable device:** These include pacemakers, implantable seizure management devices, a trach cannula, and devices for pain management.

5. **Large bone fracture or multiple fractures, dislocations or other musculoskeletal concerns:** The issue of safety needs changes as a result of aging,

a disease process or a secondary disability may need to be considered. Underlying cause of fractures will also need to be evaluated for muscouskeletal deformities, osteoporosis, and/or scoliosis.

6. **Lack of consensus re: diagnosis, treatment, treatment options or support needs**: The Clinical Consultation must provide objective analysis of the situation that can better guide appropriate care for the individual.

7. **Unexplained DNR**: This refers to DNRs that are put in place when there is no diagnosis or condition that would indicate a need for one.

8. **Multiple pneumonias/Choking Episodes/Aspiration:** The purpose of the Clinical Consultation in such cases would be to determine the cause of the recurring pneumonia, choking, or aspiration such gastroesophageal reflux disease (GERD) or swallowing disorders or in management of early symptoms of respiratory infections.

9. **Sudden, unexplained behavior change:** Underlying medical conditions undiagnosed or not appropriately treated should be ruled out prior to any type of behavioral intervention/use of psychotropic medication. Examples that may cause behavioral changes include tooth pain, constipation, ingrown toe nails, earache, headache, etc.

10. **Rapid decline in functional skills:** Underlying medical conditions undiagnosed or untreated should be ruled out prior to non-medical interventions. Examples include malaise, decreased mobility, new onset of drooling, excessive sleeping, changes in or poor appetite, decreased ability to communicate, etc.

11. **Decline in mental ability:** Underlying medical conditions undiagnosed or untreated should be ruled out prior to non-medical intervention. Examples include increased response time, decreased communication, forgetfulness, detachment, isolation, hostility, depressed mood, aggression, self-injurious, suicidal gestures/ideations etc.

When is Clinical Consultation Initiated?

A clinical consultation must be requested whenever any of the following situations occur:

1. Any of the above conditions occur or exist
2. The ISP team determines that the individual's health care status requires a more intensive clinical review.
3. The provider and /or the service coordinator requests a clinical consultation as a result of health changes or needs adjustment.

Who Initiates a Request for Clinical Consultation?

A clinical consultation request may be initiated by any of the following:

1. A supervisor, manager, health care coordinator, RN from the provider agency,
2. Family member
3. Any member of the ISP team
4. DDA nurse

Process/Flow for Clinical Consultation

1. The individual's service coordinator or service coordinator supervisor should be contacted whenever any of the abovementioned indicators are present.
2. If the provider has a nurse on staff who is assigned such duties, the provider will conduct the initial clinical review with consultation and support from the DDA nurse, if requested by the provider.
3. The service coordinator will forward a request for a clinical consultation to the DDA nurse, if the provider does not have an RN or NP assigned such duties.
4. The DDA nurse will respond to a request for a clinical consultation in a timely manner.
5. Findings and/or recommendations from the clinical consultation will be forwarded to the provider and service coordinator whose responsibility it will be to consider its inclusion in the individual's plan of care. If indicated, medical intervention will be immediately initiated by the residential provider or primary caregiver.
6. The Health and Wellness Unit will maintain a record of individuals who have received physical health care clinical consultations.
7. The DDA nurse shall review and update each individual consultation at a minimum, in conjunction with the ISP process.

Elements of the Clinical Consultation

The clinical consultation is comprised of the following elements:

1. A review of specific conditions or concern identified;
2. A general assessment of the supports needed to effectively assist the individual and/or provider to stabilize and support the individual;
3. An assessment of the supports in place to meet the individual's needs;
4. Recommendations for further referral for assessment or intervention and/or need for human rights review,
5. A determination of how often the support plan should be reviewed to determine its efficacy in meeting the individual's health care needs; and
6. A recommendation regarding staff training needed to support the individual.

9. Timeline for Implementation:

Each residential support provider shall take immediate steps to comply with the requirements of this policy by:

- Immediately implementing and complying with the DDS Protocol for Obtaining a DDA Clinical Consultation.
- Immediately disseminating the fact sheets included in the Appendix.
- Training all relevant staff on the material presented in these fact sheets no later than January 30, 2007.
- Developing and submitting to the Deputy Director a written set of policies, procedures and protocols on Identifying, Diagnosing and Treating Health and Functional Decline that incorporate and address each specific requirements and elements included in this DDS Policy no later than February 15, 2007.
- Training its relevant staff on its policies, procedures and protocols no later than March 1, 2007.
- Implementing such policies, procedures and protocols no later than March 1, 2007.
- Providing follow up training on such policies, procedures, and protocols every 45 days or more frequently if the needs of the individuals that the provider serves, warrants it.
- Monitoring and adjusting the implementation of such policies, procedures and protocols to ensure their effectiveness at least every 30 days.

10. Glossary of Key Terms:

Differential Diagnosis: The systematic method physicians use to identify the disease or condition causing a patient's symptoms. At a minimum, this is a rigorous process that stresses: (1) Weighing the probability of one possible cause against one or more others; (2) Carefully monitoring and assessing whether a particular working diagnosis proves accurate; and, (3) Reassessing diagnoses when an individual's condition does not improve.

Health Care Management Plan (HCMP) : A document, developed based on a health risk tool, that describes the supports, services, and interventions required by an individual to manage identified medical and health care risks, identifies the individual to carry out the intervention and the professional responsible for evaluating the outcome of the services, supports and interventions provided.

Health Risk Assessment (HRST): Instrument used to identify risks to an individual's health also referred to as a Health Risk Screen Tool.

Intensive Case Management: A service delivery model through which individuals requiring a higher level of monitoring, planning, advocacy, coordination of needed services and supports, and interventions due to being at high risk of harm due to medical, psychiatric, behavioral, and/or criminal circumstances.

Individual Support Plan (ISP): a document developed by a planning team that has been selected by the individual, whenever possible, to guide the process for establishing services that reflect their preferences, choices, and desired outcomes.

Licensed Practical Nurse (LPN): Nurse licensed through the District of Columbia Board, Maryland Board of Nursing, or any other Boards within the United States or nurse working under the direction of a Registered Nurse (RN) or Primary Care Physician (PCP).

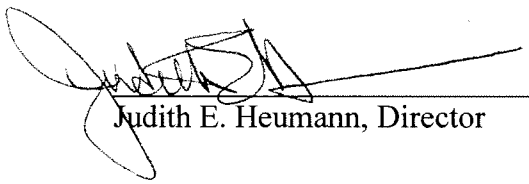
Nursing Care Plan: Plan designed by a nurse (RN/LPN, under authority of RN) to manage health.

Ongoing Health and/or Functional Decline-- Any continuing change(s) in the physical or mental health and/or functional abilities of an individual that could cause, exacerbate or increase the risk of an illness, injury, chronic pain, Emergency Room visits/hospitalization, institutionalization, ongoing intrusive medical care or result in death.

Primary Care Physician (PCP): Doctor meeting requirements of District of Columbia Board of Medicine, Maryland Board of Medicine, and/or other Boards of Medicine within any applicable jurisdiction within the United States, and principally responsible for the health of individuals under his/her care.

Registered Nurse: Individual licensed as a registered nurse through the District of Columbia Board of Nursing, Maryland Board of Nursing, and any Board of Nursing within any applicable jurisdiction within the United States.

Supervising Registered Nurse: Registered Nursed employed by the Community Residential Provider to coordinate medical and clinical services for individuals supported by MRDDA and said Community Residential Provider.



Judith E. Heumann, Director

December 31, 2007

Date

SIGNS AND SYMPTOMS OF ILLNESS

Background

The health status of individuals does not neatly lend itself to an annual review and physical exam. Clearly, we can anticipate that individuals will be subject to episodic illness or subtle changes in health status over time that, if not addressed, can lead to more serious issues. It is critical, therefore, that direct support professionals, as the first line of defense, be knowledgeable about what issues to report on and to whom they need to report them. Accurately recognizing signs and symptoms of illness will facilitate individuals receiving timely medical care.

Purpose

The following fact sheets are intended to be used as a training tool for direct support professionals. They are formatted so that they define a condition, identify observable symptoms, and recommend action for direct support professionals. The fact sheets can be used as quick reference sheets for direct support professionals and are intentionally written so as to minimize the use of medical jargon that may be non-descriptive of symptoms that the staff may be observing.

The sections included highlight a few key issues that commonly occur and may be indicative of serious health concerns requiring prompt action. The forms do not attempt to dictate agency practice with respect to action to be taken. They are meant to provide guidance to providers regarding signs and symptoms that should trigger agency response protocols.

HEALTH OBSERVATION GUIDELINES

This document is intended to provide a clearer understanding of the importance of some common signs and symptoms of illness. It explains why certain simple signs may be important clues of underlying conditions and stresses the importance of observing changes in an individual's normal status. It is formatted to follow the sequence outlined in the Direct Observation Health Form.

ABDOMINAL PAIN / BELLY ACHE

Abdominal pain or a belly ache" can be a sign of a minor temporary illness like a virus or it can be a serious problem like a blockage of the intestines. A person's report of pain should always be taken seriously. Your observations will be helpful in identifying the underlying cause of the pain.

Other considerations when someone has abdominal pain:

Has this person had this before?
- ❑ If " yes", what caused it?
- ❑ If "yes", how was it treated?
- ❑ If "yes", did the treatment work?

How bad is the pain?
- ❑ Can the person participate in their usual activity?
- ❑ Has the pain made this person stop what they are doing?

Could this be constipation?
1. When was the last bowel movement?
2. Are there other symptoms of constipation (dry, hard stools) or diarrhea (loose, frequent stools)?

Where is the pain?
- ❑ Can the person describe where the pain is?
- ❑ Can the person point to where the pain is?
- ❑ Is the pain only in one area?
- ❑ Is the pain moving all over the abdomen?

What is the pain like?
- ❑ Is it sharp?
- ❑ Is it dull?
- ❑ Is it constant?
- ❑ 4. Is it intermittent?

If the person cannot tell you about the pain or show you:
- ❑ Is the person constantly moving around, holding their abdomen?
- ❑ Does the person stop moving and relax for a while and then start moving again?
- ❑ Is the person lying down with their knees drawn up?
- ❑ Does the person have a pained expression on their face?
- ❑ Is the person moaning or crying?
- ❑ Will the person let you touch their abdomen?
- ❑ If they let you touch their abdomen does the pain seem to get worse when you do?

What about food?
- ❑ Is the person refusing to eat or drink?
- ❑ Does the pain seem better or worse after they eat?
- ❑ Do they have the pain after eating a particular food?
- ❑ Has the person vomited?
- ❑ If they have vomited, how much?
- ❑ If they have vomited, what did it look like?

Other symptoms:
- ❑ Does the person have a fever?
- ❑ Does the person have difficulty breathing?

WHAT SHOULD YOU DO?

Call 911 if:
- ❑ The person appears very ill
- ❑ Symptoms developed very suddenly and are significant enough to stop normal activity.
- ❑ The person has difficulty breathing

If you think that there may be a health problem:
- ❑ Call or talk to your nurse or supervisor according to your agency's policy
- ❑ If you think they are ill, call the doctor
- ❑ Talk to other staff about what you see
- ❑ Document what you see and what you have done to address the pain

•

ALLERGIC REACTIONS

An **allergy** is a person's abnormal response to something that is usually harmless. That material is called an **allergen**. Some examples of common allergens are pollen, dust mites, animal dander, molds, latex, insect bite, medications and certain foods. The most common allergies affect the nose (runny and sneezing), eyes (watery and itchy) breathing (wheezing and coughing) or the skin (itchy with hives or a rash). Some common terms for these kinds of allergies are "hay fever", "pet allergies", "dust allergies", allergic asthma, and "hives."
A severe and possibly life-threatening allergic reaction is called **anaphylaxis** or **anaphylactic reaction.** This is the most dangerous type of allergic reaction. **If not treated immediately it can lead to death**. Many people who are at risk for this reaction carry an epinephrine-filled syringe with them at all times. **It is called an Epi-pen.** You may need to be trained in how to use one of these devices if you work with someone who has a history of these reactions.

What does an anaphylactic reaction look like?

The most common signs of an anaphylactic reaction are:

- ❑ Hives (itchy bumps on the skin)
- ❑ Swelling of the throat, lips, tongue, or around the eyes
- ❑ Difficulty breathing or swallowing

Some other common signs are:

- ❑ A metallic taste or itching in the mouth
- ❑ Flushing, itching or redness of the skin
- ❑ Abdominal cramps, nausea, vomiting, or diarrhea
- ❑ Heart racing
- ❑ Paleness
- ❑ Lightheadedness
- ❑ A sudden feeling of weakness
- ❑ Anxiety or an overwhelming sense of doom
- ❑ Collapse
- ❑ Loss of consciousness

What should you do if you see an allergic reaction?
Call 911 if the person appears:

- ❑ To have difficulty breathing
- ❑ Complains that their throat is closing up
- ❑ To be wheezing severely
- ❑ To be unconscious
- ❑ To have severe swelling of the face, tongue or eyes or at the site of an insect bite
- ❑ Complains of dizziness
- ❑ •Gray or blue in color

Other situations:

- ❑ Consult your nurse or health care provider
- ❑ Write down what you see and what you think may be the cause
- ❑ Share what you see and think with other staff
- ❑ Share what you think and see with the HCP or nurse

ALLERGIC REACTIONS (CONT.)

How can you prevent an allergic reaction? Usually, avoiding what the person is allergic to can be the simplest way to control their allergy. Depending on what he or she is allergic to, this plan may or may not work well. If the person is allergic to dust mites, pollen, mold or pet dander, you can reduce their exposure by making a few changes in the home and lifestyle.

For example, if he or she is allergic to dust mites or mold:

- Don't allow the humidity level in the home go above 50 per cent
- Use an air conditioner in the summer
- Cover the mattress, box spring, and pillows with plastic or allergen-proof covers
- Remove rugs
- Do not use upholstered furniture
- Use washable curtains and draperies

If he or she is allergic to pollen:

- Stay indoors when the pollen counts are high
- Keep the windows in your home and car closed
- Use air conditioning

If he or she is allergic to **pet dander or cigarette smoke**:

- Keep pets outside
- Allow no smoking in the home
- Avoid exposure to cigarette smoke

If the person has a food allergy, avoiding the food is the only way to control that allergy. **Food, medication and insect allergies are the most common causes of anaphylaxis.**

What about medications? Sometimes avoiding the substance that you are allergic to is not possible. There are many different types of medications that can help lessen the symptoms. Some are available over the counter and others require a prescription. The person's health care provider should be consulted about what medication might be best.

CONSTIPATION

The body gets rid of waste through bowel movements. Every person has a pattern that is normal for him or her, whether the person moves his or her bowels once a day or every three days. The bowel movements should be soft, formed and it should not hurt or cause bleeding.
If a person has a bowel movement (stool) less often than usual, then they may become **constipated**. Constipation occurs when too much water is absorbed from the stool in the intestine and the stool becomes hard and dry. Constipation can often be prevented by increased fluid and fiber intake.

Symptoms of Constipation:

- Less frequent bowel movements (fewer than usual pattern)
- Stools that are hard, dry, difficult to pass
- Grunting or straining during bowel movements
- Swollen belly
- Belly tenderness
- Increased gas, either flatus or burping
- Decreased appetite
- Small amounts of liquid stool (liquid stool leaking around hard stool)

What causes constipation?

- Decreased fluid intake
- Some medications, especially antipsychotics, muscle relaxants or pain medications
- Drug toxicity
- Decreased physical activity like walking
- Neuromuscular disease, such as cerebral palsy
- Physical deformities that affect the intestine
- Lack of enough fiber in the diet
- Changes in toileting routines
- Stress
- Pain when eliminating – may be caused by hemorrhoids, skin irritations Obstruction in the intestine

WHAT SHOULD YOU DO?

Call 911 if the person appears:

- Gravely ill
- Gray in color
- In severe pain
- Has large amounts of blood in their stools

In other situations:

- Consult your nurse or health care consultant
- If the individual is sick, call the health care provider
- If the person is constipated, increase fluid, dietary fiber and exercise
- Check their bowel pattern over the past few days. If the person has only had small movements over the past few days, they may need a laxative (stool softener). Consult their health care provider or their routine orders for laxatives
- Notify your health care provider if there are no results from laxatives
- Notify your nurse/health care consultant/health care provider if the person is constipated more than twice per month.
- Tell other care takers what you know and see
- Write down what you see

DEHYDRATION

A person needs a certain amount of fluids; mostly water, for the systems in their body to work properly. Not enough fluids can affect every system in the body including the heart, kidneys and even the lungs. When a person loses water from their body more quickly than they take it into their body, a problem can occur. This can happen quickly or slowly. It is called **dehydration** and it is a big health problem.

Signs of fluid loss include:

- Dry skin
- Dry cracked lips
- Less elasticity to the skin
- Going to the bathroom less often Strong-smelling, dark brown or dark yellow urine
- Less urine
- Fast weight loss
- Doesn't want to participate in activities
- Sleepy, hard to wake up
- Fast heartbeat, low blood pressure
- Fever
- Reddened skin or yellowish color to skin
- Sunken eyes

WHAT SHOULD YOU DO?

Call 911 if the person is:

- Looks very sick
- Has gray skin
- Won't wake up

What can cause fluid loss?

- Loose watery bowel movements/vomiting
- Less fluid intake
- Some medications like "water pills"
- Too much of a medication in someone's blood
- Infections
- Need other people for food and drink
- Fever
- Some health problems like Diabetes
- Hot weather or a long time in a hot place
- Exercise that causes too much sweating
- Fast breathing for a long time

When you think there may be a problem:

- Call or talk to your nurse or supervisor
- If the person is sick, call the doctor
- Give small amounts of fluid often
- Write down the amount of their urine or bowel movement
- Write down how much the person drinks and eats
- Make sure the room is not too hot or too cold and the person is wearing the right kind of clothes
- Talk to other staff about what you see

DIARRHEA

The body gets rid of waste through bowel movements. Every person has a pattern that is normal for him or her, whether the person moves his or her bowels once a day or every three days. The bowel movements should be soft, formed and it should not hurt or cause bleeding.
When waste products or stool move rapidly through the intestine it allows for less water absorption by the bowels. Therefore the stool is more liquid.
Diarrhea involves frequent (more than two or three) bowel movements in a day.

Symptoms of diarrhea:

- Several bowel movements (more than two or three in a short time)
- Stools watery or even liquid
- Cramps in the belly
- Tenderness of the belly
- Increased gas
- Decreased appetite
- Stools may be an abnormal color, such as greenish
- Stools may have an unusually bad odor
- Irritation or burning of the rectal area
- What can cause diarrhea?
- Taking in more fluids
- Some medications, such as laxatives, antacids, antibiotics
- Stress
- Infections
- Problems digesting certain foods, like lactose
- Eating more high-fiber food items, such as corn or beans

There may be instances when an individual is severely constipated and liquid stool moves around the hard, formed stools giving the appearance of diarrhea or oozing.

WHAT SHOULD YOU DO?

Call 911 if the person appears:

- Gravely ill
- Gray in color
- Has large amounts of blood in their stools

In other situations:

- Consult your nurse or health care consultant
- If the individual is sick, call the health care
- provider
- Record the stool output – if frequent loose stools last longer than 24 hours, or the person has an elevated temperature or is becoming dehydrated, consult their health care provider •
- Consult their routine orders for laxatives and consider holding that day
- Share your concerns with other care takers
- Write down what you see

DYSPHAGIA AND ASPIRATION

A common problem for many of the people that you work with is dysphagia. **Dysphagia** is a word that describes any problem a person may have with swallowing. Swallowing problems can lead to aspiration. **Aspiration** is a word that means food or fluids that should go into the stomach go into the lungs instead. Usually when this happens the person will cough in order to clear the food or fluid out of their lungs. Sometimes, however, the person does not cough at all. This is what is known as a "silent aspiration." Frequent aspiration can cause damage to the lungs if it is not treated. There are several ways to tell if someone has dysphagia or aspiration problems. The person's doctor will order the tests that they think will be best for each person.

Common signs of dysphagia and/or aspiration are:

- ❑ Coughing before or after swallowing
- ❑ Much drooling, especially during meals
- ❑ Pocketing food inside the cheek
- ❑ Choking on certain foods, for example white bread
- ❑ Nose running or sneezing during dining
- ❑ Trouble chewing
- ❑ Trouble swallowing certain types of fluids
- ❑ Trouble swallowing certain types of food
- ❑ Taking a very long time to finish a meal
- ❑ Getting tired during the meal
- ❑ Refusals to eat certain foods or finish a meal
- ❑ A complaint of feeling like something is caught in the throat
- ❑ A gurgly voice during or after eating or drinking
- ❑ Much throat clearing after a meal
- ❑ Repeated episodes of choking, frequent colds, pneumonias or "allergies"
- ❑ Unexplained weight loss
- ❑ Unexplained fevers that come and go
- ❑ Coughing when lying flat or sitting up quickly from a reclined position

Conditions that may lead to dysphagia and/or aspiration:

- ❑ Aging
- ❑ Poor dental alignment or missing teeth
- ❑ Seizures
- ❑ Decreased level of awareness
- ❑ Fatigue
- ❑ Some medication side effects that weaken ability to swallow
- ❑ Poor muscle function as in cerebral palsy
- ❑ Poor eating habits described as stuffing, or rapid eating
- ❑ Some medical conditions
- ❑ Poor positioning or posture while eating

WHAT SHOULD YOU DO?

Call 911 if the person is:

- ❑ Blue, can't talk or make a sound or is not breathing (Attempt Heimlich Maneuver)
- ❑ Having difficulty breathing
- ❑ Looks very ill

If you think there might be a problem with swallowing:

- ❑ Document what you see
- ❑ Tell other staff what you see
- ❑ Tell the nurse or your supervisor what you see
- ❑ Offer foods that the person seems to tolerate better
- ❑ Stop the meal if the symptoms worsen and report it to the nurse or your supervisor according to your agency's policy
- ❑ Have the person eat at a slow pace
- ❑ Tell the doctor what you see

If a person has tests that show they have trouble swallowing the doctor will tell you what you need to do. You must do exactly what the doctor tells you to do or you may cause harm to the person.

FALLS

Falls can happen for many reasons. It is not normal to fall. If someone is falling a lot (as often as once a week), the reason for the falls needs to be determined. Some of the reasons that someone might fall are:

- ❑ **Seizures** – a fall can occur during the seizure or right after the seizure when a person is not yet fully recovered.
- ❑ **Body deformities** – curvature of the spine, one leg shorter than the other leg, club foot, tight heel cord, poorly healed fracture
- ❑ **Balance problems** due to medical conditions like cerebral palsy, tremors, or a stroke
- ❑ **Medications** –Many medications can affect a person's balance. A change in dose can also affect his or her balance.
- ❑ A **change in vision**, new glasses, broken glasses, eye infection, ear infection, headache
- ❑ **Foot problems**– sore toes, new shoes, poorly fitting shoes or braces
- ❑ **Clothing** – loose baggy clothing, untied shoes, pants that are too long, soles of shoes that are too slippery or "catch" on carpet, ueven, wet or slippery **walking surfaces**, bad lighting, loud noises, walking too fast, or blocked pathways
- ❑ **Tiredness** or an illness causing the person to have a decrease in their energy level
- ❑ An **increase in energy** that causes a person to move too quickly or be distracted easily
- ❑ An **injury** that causes a person to change how they walk in order to protect the injury

---

IF SOMEONE FALLS, WHAT SHOULD YOU DO?

Call 911 if the person:

- ❑ Is in a lot of pain while lying still or when they move
- ❑ Has an obvious deformity (bone sticking out, swelling or unusual position of arm or leg or head)
- ❑ Is unconscious
- ❑ Gray in color
- ❑ Anytime someone falls, whether they appear to be hurt or not, they need to be thoroughly examined for any possible injury. Do not move them until it has been determined that a serious injury has not occurred.

The fall and all that you see after the fall needs to be written down and reported to other staff members. Often the injury will not be obvious right away (like bruising), but if the fall has been reported with details about how the person "landed", bruises that show up later can be explained.

Look for:

- ❑ redness
- ❑ scrapes or abrasions like "rug burns"
- ❑ cuts or bleeding
- ❑ swelling
- ❑ any complaint of pain and where that pain is and when they complain. For example, " Joe complains of pain in his right knee when he kneels on it."

Once you have taken care of the person who fell and written the report of the incident you may also need to:

- ❑ Tell your supervisor or the nurse about the fall
- ❑ Fix whatever caused the fall (if you can)
- ❑ Write down and give to your supervisor and other staff a list of unsafe conditions that are still present (like a slippery sidewalk, or wet floor or broken equipment)
- ❑ Think about what would prevent more falls and talk about it with your supervisor and other staff

"JUST NOT RIGHT"

Many individuals are not able to tell us with words how they feel or what exactly is bothering them. But they can and do frequently tell us by a change in the way they act or the sounds they make. Often, it is the direct service provider who knows the individuals the best and is able to pick up small changes that could be signs of illness. When such changes happen direct service providers often describe the individual as "not right", "something is wrong", " not themselves". How the change is described to a physician will make a difference in the physician's ability to understand the value of the observation, figure out what the problem is and treat it.

When you notice that someone is not right, it may be helpful to think about describing your observations by comparing them to how the individual usually behaves or appears. When you look at the person or think about what you are seeing, what is different from what you usually see?

Does he / she have a different **look on their face**? Tired, afraid, in pain? ❑ Are they sitting or **moving differently**? Protecting a hand or foot, refusing to take a position that is normal for him/her? ❑ Is there a change in the type of **sounds** a person is making? Are they more highly pitched? Or perhaps they are not making any sounds at all. ❑ What is their **temperature**? ❑ What is their **breathing** like? ❑ What is their **color** like? Pale or red? Blue around the lips? ❑ Have you seen this before? When? What was going on? ❑ Has there been a recent **new medication**, adjustment to medication or diagnosis that might help explain the change? ❑ Sometimes a **significant change** in a person's life or relationships will cause behavioral or physical signs. Has there been a death or loss of a person or a change in a routine? ❑ Are they eating and drinking? If so, is this different than their usual pattern? ❑ Is there a change in their bowel or bladder habits? ❑ Has there been a change in their willingness or ability to participate in activities? ❑ When did you notice this change? Did it just start today, or has this been a gradual change?	IF YOU NOTICE CHANGES, WHAT SHOULD YOU DO? **Call 911** if this happens: ❑ The change is very sudden ❑ The person looks very sick ❑ The person won't wake up In other situations: ❑ Call or talk to your supervisor or nurse about what you see or hear ❑ Write down what you see or hear and sharethe information with other staff. ❑ Talk about what you see and hear with other staff and write down what they report ❑ Make a physician appointment ❑ Keep notes of what you see and hear and bring them with you to the Dr.'s appointment to assist the physician in diagnosing the problem.

SEIZURES (EPILEPSY)

What is a seizure?
The brain is full of electrical activity. It is how the brain 'talks" to the rest of the body. If there is abnormal or excess electrical activity in a part of the brain it can cause a misfire and result in a **seizure** or **convulsion.** People who have reoccurring seizures are said to have **epilepsy.** This is not a disease but rather a word used to indicate recurrent seizures.

What can cause a seizure?
Sometimes the cause of a seizure is never known. .
However, in most cases the cause is likely to be caused by one or more of the following:

- High fevers in children (102 degrees or higher)
- Epilepsy, a brain disorder
- Brain injury, tumor or stroke
- Electric shock
- Poisons
- Infections of the brain or nervous system
- Reactions or overdoses to medication or drugs
- Snakebites
- Reaction to vaccinations
- Alcohol
- Choking
- Heart disease
- Heat illness
- Toxemia in pregnancy
- Medication withdrawal
- Low blood sugar
- What does a seizure look like?

Seizures fall into two general groups: **general** and **partial**. A **partial seizure** affects small parts of the brain. A **general seizure** affects the whole brain and can cause loss of consciousness and/or convulsions. This is the type that most people think of when the word "seizure" is mentioned.
This type of seizure is also called a **tonic-clonic** or a **grand mal seizure**.The important thing to know is that for most people with epilepsy, their seizures usually look the same. **Knowing how the person you work with looks or behaves when they are having a seizure is very important in order for you to be prepared to keep the person safe during and after the seizure.**

Some typical symptoms of a general seizure (tonic-clonic) are:

- Drooling or frothing at the mouth
- Grunting and snorting
- Tingling or twitching in one part of the body
- Loss of bladder or bowel control
- Sudden falling
- Loss of consciousness
- Temporary absence of breathing
- Entire body stiffening
- Uncontrollable muscle spasms with twitching and jerking limbs
- Head or eye deviation (fixed in one direction)
- Aura before the seizure which may be described as sudden fear or anxiety, a feeling of nausea, change in vision, dizziness, or an obnoxious smell.
- Skin color may be very red or bluish.

Some typical symptoms of a partial seizure are:

- Glassy stare or rapid blinking
- Give no response or an inappropriate response when questioned
- Sit, stand or walk around aimlessly
- Make lip-smacking or chewing motions
- Fidget with or pick at clothes
- Appear to be drunk, drugged, disorderly or psychotic

SEIZURES (EPILEPSY) (CONT)

Most seizures last from a few seconds to five minutes. Again, knowing how long a seizure usually lasts for the person you work with is very important so that you will know when to seek emergency help if it lasts longer than usual.

What should you do when someone is having a Tonic-Clonic (Grand Mal) seizure?

During the seizure:

- ❑ DO remain calm, be a good observer. Speak calmly and softly to the person.
- ❑ DO help the person into a lying position and put something soft under the head.
- ❑ DO turn the person to one side (if possible) to allow saliva to drain from the mouth.(If not possible during the seizure, do so once the seizure has stopped).
- ❑ DO remove glasses, loosen ties, collars and tight clothing.
- ❑ DO protect the head and body by clearing the area of hard or sharp objects.
- ❑ DO NOT force anything into the person's mouth or between their teeth.
- ❑ DO NOT try to restrain the person. You cannot stop the seizure.

After the seizure:

- ❑ DO arrange to have someone stay nearby until the person is fully awake.
- ❑ DO clear the airway of saliva and / or vomitus
- ❑ DO NOT offer any food or drink until the person is fully awake.
- ❑ DO document the seizure including what happened just before it started, what happened during the seizure, how long it lasted and how long it took the person to recover.
- ❑ DO report the seizure according to your agency procedures
- ❑ DO allow the person to rest. Most people will sleep soundly for a period of time following the seizure.

What should you do if someone is having a partial seizure?

During the seizure:

- ❑ DO remove harmful objects from the person's pathway or gently guide them away from harm
- ❑ DO NOT try to stop or restrain the person

- ❑ After the seizure:
- ❑ DO stay with the person until they are fully alert
- ❑ DO NOT offer any food or drink until they are fully alert
- ❑ DO allow the person to rest or sleep
- ❑ DO document the seizure including what happened just before it started, what happened during the seizure, how long it lasted and how long it took the person to recover.
- ❑ DO report the seizure according to your agency procedures

CALL 911 IF:

- ❑ The seizure lasts for more than 5 minutes
- ❑ The person has one seizure right after another
- ❑ The person appears to be injured •
- ❑ The person does not regain consciousness
- ❑ This is a first time seizure
- ❑ The person color remains poor
- ❑ The person does not start breathing within one minute after the seizure has stopped (Start CPR)
- ❑ The seizure looks very different from the person's usual pattern

HEALTH STATUS INDICATORS

Following are signs of a person's health status that may be indicators of illness. Observing and reporting them to your supervisor and the health care provider will help the health care provider to treat the illness appropriately. The health care provider needs to understand what is "normal" for that person and what is different now. Sometimes it is not enough to report what you see. Understanding why what you see may be important will make you a better reporter. The information below may help you get ready for a visit with the health care provider.

HABITS

Smoking and drinking alcohol may cause a person to have health problems based on how often and how long they were used. •Regular exercise is a healthy habit. No exercise may cause a person to have health problems. It is important for a health care provider to understand a person's sexual activity to be able to provide testing or counseling if necessary.

SLEEP

Sleep is important in order to stay healthy. Lack of enough sleep can cause tiredness during the day and daytime napping. It is helpful for the health care provider to know when there is a change in a person's sleep pattern, whether it is an increase in the amount of time sleeping or a decrease. • Having trouble falling asleep may be a symptom of depression. • Having trouble getting comfortable without adding extra pillows may mean a person has a new health problem. Many trips to the bathroom during the night may mean a person has prostate problems or a urinary tract infection. • Waking up several times during the night and going back to sleep may mean a person has sleep apnea, which means the person stops breathing for short periods of time while sleeping which causes them to wake up briefly. Sometimes they may snore loudly.

EATING/WEIGHT

Usually a person's weight does not change much without a reason. We all tend to slowly gain weight as we get older and our metabolism slows. Other things that can affect weight include:
A change in activity level or home can make a difference.
Many of the medications prescribed for "behavior" can make people gain weight.
Weight loss when someone is not trying to lose weight is a concern. A big weight loss can mean that a person is seriously ill. It may also mean that a person is not eating well because of dental pain or painful swallowing.
A very common problem in the individuals we serve is **Dysphagia.** Dypshagia is a swallowing disorder that causes a person to have difficulty chewing and/or swallowing food. Causes of dysphagia can include: aging, medication, and neurological disorders. Food can go "down the wrong tube" and end up in the lungs (aspiration). This can happen with no observable change in the person like coughing. This is called "silent aspiration".
More frequently there are signs that we can see and that need to be reported: trouble chewing or swallowing, coughing during or after a meal, tiring during a meal and being unwilling to finish the whole meal, avoiding certain foods, textures or temperatures, nose running and sneezing during the meal.

The health care provider needs to know if these symptoms are occurring. Testing will assist him/her in prescribing a safer diet that will minimize the likelihood of long-term damage to the lungs.

CARDIAC

Heart conditions can occur in many individuals from birth or develop as they age.
Swelling of the feet and ankles, or being cold to the touch, may be a sign of a change in circulation for an individual.
A grayish/bluish color to the lips or nails may mean poor circulation as a result of heart problems.
When a person has this symptom while exercising or develops chest, jaw or left arm pain, it is a more urgent situation that the health care provider needs to know about. **Continuation of these symptoms can be a life-threatening emergency. They should not be ignored.**

RESPIRATORY

It is not normal to have frequent colds, coughs, sneezes or trouble breathing. Some chronic conditions may increase the frequency of these symptoms. These include asthma, cardiac disease, allergies and aspiration. It is important to report such symptoms to the health care provider. Tests or medications may be prescribed to reduce the frequency or severity of the symptoms.

GASTROINTESTINAL

The gastrointestinal tract is made up of organs that help us digest food and eliminate the waste from food. Gastrointestinal /bowel problems are a frequent complaint of the people we work with. Complaints can mean a chronic problem is getting worse or that a person has a new problem. Sudden abdominal problems are often the cause of a person being admitted to the hospital. The key is to know what's normal for the person.

- Significant abdominal pain is not normal and should be considered an urgent problem.
- Frequent vomiting, burping and heartburn may indicate a developing problem with the stomach or esophagus (food tube).
- Bowel movements should occur with frequently enough for the person to be comfortable. This may be daily for some and not less than every 3 days for others. Medication, illness, diet, and fluid intake may all change the pattern. An unexplained change may be important. Increased constipation may result in a bowel obstruction. Frequent loose stools (diarrhea) may be caused by infectious bacteria. Prolonged diarrhea can result in dehydration.
- Blood in the bowel movement may be a sign of hemorrhoidal bleeding or cancer. A change in bowel pattern, consistency, and frequency may be an important sign.

NEUROLOGICAL

Many individuals have known seizure disorders. The symptoms may vary. Seizures may affect the entire body and result in an individual trembling and losing consciousness. They may also be minor eye blinking with no loss of contact with activity. A seizure
disorder can occur at any time of life. It is very important to seek immediate medical attention for the first seizure that someone has. It may be of unknown cause or may result from a fall with a blow to the head. A new seizure disorder must be carefully looked at to rule out brain tumor. As in other areas, it is important to know what is normal for this person. A change from this is important to report to the health care provider. Anticonvulsants are prescribed to treat seizures. Common anticonvulsants are Dilantin, Phenobarbital, Lamotrigine, Valproic Acid, and Tegretol. These medications are used to lessen the symptoms and severity of a seizure as well as how often they occur. It is possible for these medications to "build up" in the blood and cause a person to become "toxic" or sick. People who are

toxic may appear more tired or have difficulty maintaining their balance. Sometimes people may have a seizure as a result of being toxic. The only way to know for sure is to call the health care provider and obtain a blood test to see how much of the medication is in the person's blood.

SKIN and NAILS

- Skin protects the body. It can also tell us about what is happening in the body.
- Skin should be in good repair, soft and elastic without rash and irritation.
- Dry skin may be the result of inadequate fluid intake or exposure to harsh conditions or products.
- Rashes could be signs of many things like, allergy to a medication or substance, a skin condition like eczema or a serious illness like chicken pox.
- Changing or growing moles and new lumps need to be reported and investigated as possible signs of skin or other cancers.
- Frequently the faster a symptom becomes a problem the more urgent the problem. The occurrence of a new rash or a severely itchy rash is worth reporting. Often we know where the irritation comes from, a blister on a new shoe or a red mark from a brace. While these are small problems they can be a big problem in day-to-day activity. Not knowing the source of a skin problem is much more serious.

MOUTH

Rarely is a dental issue an emergency. However poor oral health will result in sensitive teeth, gum and tooth infections, and tooth loss. Tooth loss may mean a person cannot eat a balanced diet. Good dental health is vital to overall good nutrition and good health.

- Bad breath may be a sign of oral infections.
- Certain medications may cause a person to have bleeding gums, which can cause mouth pain and infections.
- Medications that treat seizures can cause the gums to swell and grow too much.
- Good oral care is vital when a person is on these medications.
- Infections that start in the mouth can get into the blood and cause infections in other parts of the body.

VISION/HEARING

Vision and hearing are very important to a person's ability to be involved in and benefit from their daily activities. Many individuals have conditions that affect their vision and hearing. Aging causes some expected changes. Usually this happens gradually and we need to be very observant to notice changes. Any sudden change is an urgent situation.

- Redness or drainage from the eye may be a sign of an infection.
- Redness and pain may be a sign of a serious problem with pressure in the eye called glaucoma. These are urgent situations that require a visit to the health care provider.
- Squinting, needing to move into better light or sitting closer to the TV may well indicate a change in eyesight. It might be time for glasses or new glasses.
- Drainage from the ear is always a problem that must be referred to the health care provider. Many people have problems with wax build up in their ear canals.
- Earwax may effect hearing or decrease the ability of a hearing aid to work.
- Loss of hearing can cause a person to have unusual behavior, including depression.

Whenever a change in vision or hearing is noticed the health care provider needs to know about it and how much it affects the person's daily activities.

MOBILITY / MUSCULOSKELETAL

A person's muscles and bones allow them to be mobile, sit in a chair and participate in activity. As people age there may be a significant change in their comfort level or ability to move around. We all tend to develop aches and pains as we age. We adapt to those changes by not walking quite as fast or shifting in our seat more often.

Many people may have a bone deformity as a part of their lifelong health problems. An example is scoliosis that affects how they sit or move about.

Seizure medications can cause or worsen osteoporosis (brittle bones), increasing the risk of fractures.

• People who cannot walk or stand or who cannot participate in weight bearing activity are also more prone to osteoporosis.

The health care provider will look at these symptoms of pain or discomfort in movement and order treatments or exercise to maintain a person's ability to move about. The health care provider will need to know what special shoes or equipment a person uses in order to have a clear understanding of how the symptoms affect the person.

GENITOURINARY

It is important to note the normal pattern for a person regarding their urinary or reproductive system. A change from the normal pattern needs to be reported to the health care provider. Urinary tract infections (UTI) are a common problem seen in many people especially if they are incontinent and wear protective underwear.

Strong, foul odor, going to the bathroom frequently and burning on urination are all signs of a UTI. Increased accidents may also be a sign of a UTI.

There are changes to a person's pattern of urination that are part of the normal aging process. For example, the prostate enlarges in many men. These men will report dribbling or difficulty starting and stopping to urinate. They may need to urinate more frequently.

Women's menstrual cycles generally have a pattern to them. Pain during a woman's cycle may affect her ability enjoy certain activities. Changes in the cycle may be normal or indicate a new problem. Unusual vaginal bleeding or discharge requires reporting to the health care provider.

BEHAVIOR

How a person is acting can be an indication of how they are feeling. While everyone is different, there are some observations that can be made that will assist the health care provider in asking the right questions. The most important key is to note change from a "normal" pattern.

If someone begins having difficulty sleeping or is very anxious and argues easily, this may indicate a new behavioral/psychiatric problem. It may be an understandable response to a new situation or an illness. Identifying the problem will help decide what treatment is best.